Health Services
LOS ANGELES COUNTY

Expected Practices

Specialty: Gastroenterology

Subject: Personal History of Polyps

Date: July 11, 2014

Purpose: Practice recommendations for patients with Personal History of Polyps.

Target Audience: Primary Care Providers

Expected Practice: Patients with a history of previous polyp(s) on previous colonoscopy need to be referred via eConsult with a copy of the colonoscopy report and polyp pathology. The documentation should be attached to the eConsult referral. If documentation cannot be obtained, order fecal occult blood test 10 years from prior colonoscopy.

If previous polyps were not adenomas on histology, the patient is at low risk. Fecal occult blood test should be done 10 years from prior colonoscopy (if patient is over 50).

If there were 2 or fewer polyps with tubular adenomas on histology and all are less than 1 cm in size, recommend colonoscopy 10 years from last colonoscopy. eConsult should be submitted along with documentation of polyp pathology.

Patients with 3 or more tubular adenomas, an adenoma larger than one cm or an adenoma with villous histology are considered at higher risk. The patient should receive a colonoscopy 3 years after the last colonoscopy. If the patient has not had a colonoscopy within this time, request surveillance colonoscopy via eConsult along with prior report and pathology.

This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.